American Arbitration Association
Dispute Resolution Services Worldwide

MEDICAL INFORMATION FORM

AAA CASE NUMBER:

Purpose of this form: To collect information from the treating provide, Insurer, and any independent medical examiners (IME), necessary for determining the disposition of cases in dispute.

Enclose FOUR COPIES of any redacted medical records submitted for review.

The legibility of medical records is important to the review process.

Any medical records submitted must not identify the Carrier, or if ever having been identified, the Carrier's name has been deleted. This is in compliance with State Statutes. Parties are advised that additional records may be requested to enable completion of the review and determination.

A: MEDICAL REVIEW REQUEST SUBMITTED FOR DETERMINATION OF THE FOLLOWING: (CHECK AT LEAST ONE)

1. ___ If the medical treatment or diagnostic test is medically necessary, specifically _____
_____
_____
_____

2. ___ If medical procedures and tests were repeated, was there medical necessity, specifically _____

_____
_____
_____

3. ___ If the treatment is in accordance with medically recognized standard protocols, including care paths for treatment of accidental injury to the spine and back approved by the Commissioner and set forth in N.J.A.C 11:3-4, specifically _____

_____
_____

4. ___ If treatment is consistent with the symptoms or diagnosis of the injury, specifically _____
_____
_____

5. ___ If the injury is causally related to the accident, specifically _____

_____
_____

6. ___ If the treatment is of a palliative, rather than restorative nature, specifically _____

_____
_____

MEDICAL SPECIALTY REQUIRED FOR THIS REVIEW (REQUIRED):
(Please note that the request for more than one specialty will require an additional fee of $900.00 for each additional specialty)_____
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B. REQUESTED MEDICAL RECORD INFORMATION

1. **Birth Date** _____ **Gender** _____
2. **Date of Accident** _____ **Effective Policy Date** _____
3. **Patient's Relevant Past Medical history:** _____
4. **History of events related to the accident:** _____
5. **Specialty of treating provider** _____
6. **Diagnoses:** _____
7. **Diagnostic Test, procedures, treatment and therapies to date:** _____
8. **Dates of treatment or admission for all services:** _____
9. **Dates and types of surgery, if applicable, including outcome, place or hospitalization or other institution (such as rehab) if applicable:** _____
10. **Reason for continued treatment as documented by treating provider:** _____
11. **Treatment plan and timetable (services requested and number of visits):** _____

Please include summaries of all: (1) X-rays, MRI's, CAT Scans, etc., (2) Lab tests and results, (3) Dates and copies of all previous Independent Medical Examinations or opinions from other providers related to the case in question.